East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Plan Document for 2013/14

East Kent Hospitals University NHS Foundation Trust

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

This document completed by (and Monitor queries to be directed to):

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Date	**FINAL Draft for Trust Board – 17th May 2013**

The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;
- The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;
- The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;
- All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Mr Nicholas Wells

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Mr Stuart Bain

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Mr Jeff Buggle

Signature

Contents

East Kent Hospitals University NHS Foundation Trust
Strategic Plan 2013/14 – 2015/16

1. Strategic Context

1.1 Overall Trust Strategy

The Trust strategy is to remain the hospital of choice for all our patients. In the changing NHS environment, the Trust will continue to repatriate specialist services to provide a more local high quality and affordable services for the population of Kent. The aim will be to deliver high quality care effectively and efficiently to the local population enabling future investment in our services. The Trust maintains six Strategic Objectives that cover a range of domains; quality, stakeholder engagement, innovation & improvement, business development; infrastructure and finance, which in turn drive the Annual Objectives for 2013/14.

SO 1: Deliver excellence in the quality of care and experience of every person, every time they access our services.

SO 2: Ensure comprehensive communication and engagement with our workforce, patients, carers, members, GPs and the public in the planning and delivery of healthcare

SO 3: Place the Trust at the leading edge of healthcare in the UK, shaping its future and reputation by promoting a culture of innovation, undertaking novel improvement projects, and rapidly implementing best practice from across the world

SO 4: Identify and exploit opportunities to optimise and, where appropriate, extend the scope and range of service provision

SO 5: Continue to upgrade and develop the Trust's infrastructure in support of a sustainable future for the Trust

SO 6: Deliver efficiency in service provision that generates funding to sustain future investment in the Trust

Covering the next three years, the Board has identified a set of key priorities that underpin both the Strategic Objectives and the Annual Objectives for 2013/14. The key priorities will ensure that the Trust continues to focus on providing high quality care to its patients by:

- increasing the amount of care that is delivered locally;
- expanding its efficient and effective work programmes;
- reviewing and improving its input into community delivered care;
- developing long term quality and stakeholder engagement strategies alongside a clinical strategy;

To underpin these priorities, delivery of the Trusts financial plan is essential.

1.2 2012/13 Performance Impact on the 2013/14 Plan

The Trust moves forward on a strong financial base resulting predominantly from prudent planning and an engaged workforce. The underlying surplus for 2012/13 was £8.4m (before adjusting for asset impairments), delivered through strong financial governance and by achieving a savings programme of £30.6m, thus enabling a capital investment programme of £22.2m. However, demand pressure on hospital services as seen in the final Quarter of 2012/13 is expected to continue into 2013/14. The impact of this has led the Trust to reassess its expected performance against the 2013/14 Compliance Framework. Of the thirty-seven targets and indicators, three are

at risk of not being delivered in 2013/14. These are A&E – Total time in A&E under four hours and both the Clostridium-Difficile (C.diff) and MRSA Infection Rate targets. Along with this risk review and an early assessment of the impact of the Francis Report on the Trusts current service provision, it may be that more funds are required to be invested in year. The Trust has taken an extremely prudent view and has increased its contingent reserves by over 30% to cover any potential cost increases of further improving the quality of services and mitigation of these risks. In view of the level of uncertainty, the Trust Board has decided to increase its contingencies and reduce the Trust planned Financial Risk Rating to 3.

1.3 Background Strategic position of Trust within the Local Health Economy

Within East Kent, the East Kent Commissioning Federation oversees the work of five local Clinical Commissioning Groups (CCG's). This forms one of three Kent CCG Clusters, the others being West Kent and North Kent. The CCG clusters are relatively aligned to Acute provider boundaries. The Trust previously contracted with one dominant PCT plus 3 others on a smaller scale but now has four dominant CCG's and South England Specialist Commissioning Group. The Trust is proactively building positive, constructive relationships with the Kent CCG's with an aim, in part, to raising awareness of any changes to commissioning intentions and enabling a targeted response. Commissioners are routinely testing the market and advertising opportunities for different organisations to deliver both clinical and non-clinical services. The Trust is very aware that this will include the services we currently provide.

1.4 Marketing Assessment

The local geography, population masses and the distance between major hospital sites along with the local transport infrastructure and the proximity to London are all important factors when considering where services are best delivered from and what the potential impact other providers might have on the Trust.

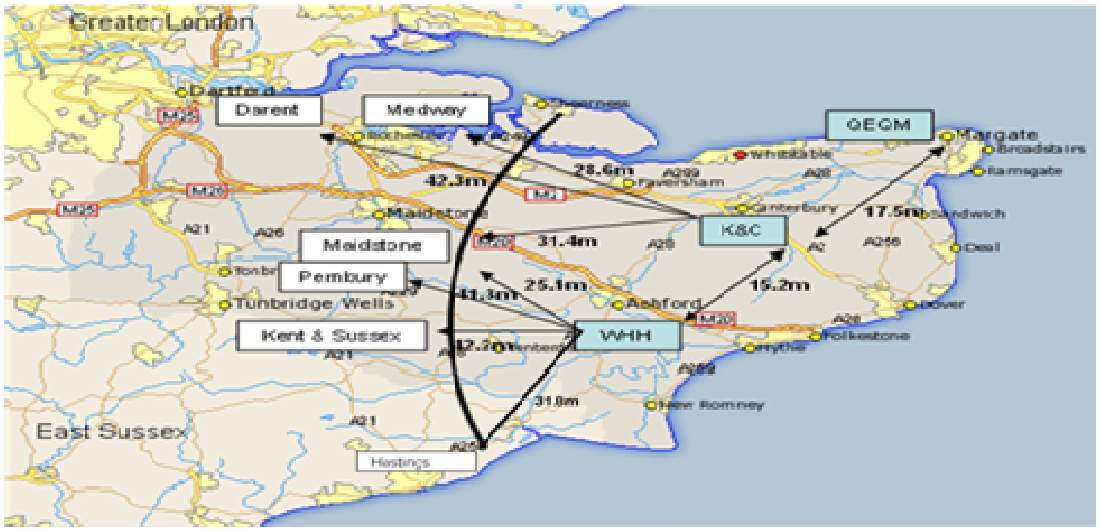

Table 1 – Distances between major Kent acute hospitals

The Trust operates from three acute sites and several non-acute/ community sites. There appears little geographical threat to demand for services at Queen Elizabeth the Queen Mother Hospital in Margate (QEQM) but there is an increased level of threat to William Harvey Hospital in Ashford (WHH) and the Kent & Canterbury Hospital (K&C) particularly with the potential merger of two West Kent Trusts and the

opening of the new single room Pembury Hospital in 2012 near Maidstone. The Trust recognises the importance of not losing sight of potential threats from these and other organisations in Surrey and Sussex. This is particularly the case with the introduction of modern technology such as tele-health and telemedicine, which can help deliver care closer to home from further a field. However, conversely the Trust also plans to take advantage of this to both help provide care closer to home efficiently and effectively in what would have been traditionally regarded as a remote location in its own patch and to secure new business in areas not generally regarded as the Trust's catchment area. This is the approach the Trust has taken with developing both its Marketing and Clinical Strategy, focussing on areas of provision in which the Trust has expertise and building in the use of tele-health, hospital at home, one-stop outpatient attendance models and ambulatory care to both utilise Trust resources most effectively and provide the best quality care to patients.

1.5 Market Expansion and Repatriation

Along with nine established independent healthcare providers across Kent, there is a new market entrant in the form of the Kent Institute due to open in the summer of 2013. Based in Maidstone, the Institute plans to introduce specialist tertiary clinical services to Kent, including Neurosurgery and robotic and laser guidance assisted surgery. It is also planning to focus upon research and innovation, supporting a drive to attract specialists normally located in London. The development of this service may impact on the Trust's own plans to repatriate services back to East Kent in specialist areas. However, the Trust has been building on repatriation plans and intends to increase market share in the Specialty areas outlined in Table 2 below.

Specialty	OP New	OP F/Up	EL Day Case	EL Inpatient
Gynaecology	20	20	20	
General Surgery	50	50	50	
Urology	88	88	80	8
General Medicine			280	
Cardiology	499	499	499	
Thorasic Medicine			60	
Total	**657**	**657**	**989**	**8**

Table 2 – EKHUFT Repatriation Plans

The Trust has recently developed a three year R&D Strategy agreed in early 2013 and in addition, has partially mitigated the threat of independent provider provision in East Kent through taking ownership of The Spencer Wing in December 2012 which is now a wholly owned subsidiary of the Trust.

The Trust is also exploring several strategic avenues to potentially expand into West Kent.

- For Vascular services, the Trust already hosts the Kent & Medway national Aortic Aneurysm Screening Programme. The Trust plans to develop a business case to explore the viability and potential improvement in the financial position of vascular services by expanding into West Kent and also offer vascular services in Sussex where Hastings hospital has been decommissioned.
- In building on Trust strengths, the Trust is currently exploring cross working with East Grinstead for Maxillo-Facial Services to become the only comprehensive Head and Neck Cancer Unit outside of London.

- The Trust is planning an external review, as part of the Clinical Strategy, for the provision of a Kent-wide network for Spinal Surgery which may result in a positive site consolidation.
- Potential expansion of the Interventional Radiology service in collaboration with General Radiology

These are current opportunities however Trust has taken a prudent view and as there is no sufficiently reliable details yet, the financial impact has not been included in the Trusts forward plan. Decisions on service viability and sustainability will be made as details become clearer and each option is developed through 2013/14. Any potential investments decisions will be made by the Board of Directors following these reviews.

1.6 **Local Commissioning Strategy**

In their Notice of Commissioning Intentions for the 2013/14 contract, the Commissioners stated a list of their Commissioning priorities. Evidence suggests from the past few years that the level of Commissioning Intentions published by Commissioners has little effect on demand growth.

The CCG's have stated that they are currently reviewing their AQP priorities but have not stated any specific areas of review in 2013/14. Whilst the Trust is not able to explicitly forecast when Commissioners plan to tender local services, the Trust has a process around how new market opportunities are agreed; how and who applies for a tender opportunity and which body signs off the bid process. This will ensure that we do not miss an opportunity to develop the business or retain core business. Tenders are advertised though electronic portals which the Trust monitors on a routine daily basis. The Executive Team receives a weekly update for review and a decision on whether or not to participate in the tender process. The Trust is also developing a 'response unit' approach to the publication of larger tenders.

The Trust remains committed to supporting the shift of care delivery outside hospitals and is an active participant in the local Integrated Plan Board (plus Whole Systems Delivery Board & East Kent Commissioning Federation). Plans to integrate services better to provide better care and increase local health economy efficiency including partnerships and collaborations such as the Integrated Urgent Care Centre (IUCC) and developing a Healthcare Village are underway and included in the financial plan where proposals are sufficiently developed.

1.7 **Forecast Health Demographic & Demand changes**

For 2013/14, detailed activity modelling has been undertaken at Specialty level to formulate plans based on the Trusts historic demand profile, adjusted for capacity, known service developments or reconfigurations and Commissioning Intentions (where the Trust is in agreement with Commissioners).

Beyond 2013/14 into the two further years, to improve the robustness of forward year growth planning, the Trust has undertaken demographic modelling building on the 2013/14 planning assumptions. In East Kent, the population is expected to grow by 10% over the next twenty years, increasing to 25.8% growth in the over 65's. The Trust has analysed this change and also how different age groups and different localities access our services and from this has derived a natural income growth per annum of 0.8% (on average over service headings and not including the impact of potential Commissioning Intentions). In 2013, the Trust will continue with further work to assess any potential future peaks and troughs in the estimated forward growth.

1.8 **2013/14 Annual Objectives**

In assessing all the key deliverables of the Trust for the forward year, the Trust has agreed a focus on twelve Annual Objectives for 2013/14 that encompass the key priorities of the Trust and underpin the Strategic Objectives and priorities.

AO 1: Implement the second year of the Trusts Quality Improvement Programme, demonstrating improvements in patient safety, clinical/ health outcomes and patient experience.

AO2: Deliver the CQUIN programmes commissioned by the CCGs demonstrating quality improvement and associated financial benefits.

AO3: Develop a Trust wide infrastructure and/ or systems that integrate service improvement and innovation with Quality, Clinical and Financial Strategies to deliver person centred, safe and effective care.

AO4: Reduce the number of unplanned readmissions within 30 days of discharge following an episode of carte where there is a direct link to the index admission.

AO5: Reduce the risk and impact of a business continuity disruption by strengthening and testing business continuity plans throughout the Trust.

AO6: Engage with the new local Healthwatch and Wellbeing Boards while further developing relationships with vulnerable patient groups and local voluntary and community organisations to strengthen the understanding between the Trust and these key stakeholders.

AO7: Increase research capacity by focussing on improvements in communication training and reducing the bureaucratic burden for researchers.

AO8: Implement the Marketing Strategy to meet repatriation and market share targets for inpatient and day case procedures.

AO9: Support increased efficiency and effectiveness across the Trust via the implementation of major infrastructure projects for combined heat and power plants, the capital build programme, implementation of the sustainable development management plan and working towards a complete electronic patient record in line with the Information Management & Technology Strategy.

AO10: Agree with Commissioners to consult with the public to implement a sustainable Clinical Strategy which will meet the standards of emergency surgery, look to provide a trauma unit, ensure availability of an appropriately skilled workforce, provide safe and sustainable services with consideration of access for patients and visitors.

AO11: Develop and deploy analytical approaches to support strategic evidence based decision making and provide clinicians with real time business intelligence.

AO12: Ensure strong financial governance, agree contracts with Commissioners that deliver sufficient activity and income and support a comprehensive internal cost improvement programme where all Divisions deliver cash releasing savings schemes to meet Trust QIPP targets.

1.9 **Trust Membership**

The Trust continues to plan an increase in public membership by a further 500 in 2013/14 to 11,588 in line with that delivered in 2012/13. For staff membership, little change is expected to existing numbers (as at the end of March 2013) following a significant increase over the past year. The numbers of candidates standing as Governors improved in 2012/13 compared to the previous year along with votes cast and turnout rates. Both By-Elections in 2012/13 for the four seats were held in accordance with the election rules within the FT Constitution. Over the previous 12

months, specific events have been initiated to develop a larger and more representative profile of public members. This has included recruiting volunteers as members, as well as attending Freshers Fairs in colleges and universities to recruit younger members. This is now reflected in the good level of 17 to 21 year old membership. In terms of ethnicity, the public and staff membership better matches the local population profile than it did prior to 2012/13. The work with hard to reach groups will continue into 2013/14 as will work to encourage a younger membership through links with schools and by providing hospital tours for pupils. In addition, dedicated meetings to engage with and recruit members will take place around specific health issues (e.g. dementia), including a presence in local shopping centres, to explain the work of the Trust and the positive benefits of Trust membership.

1.10 **Council of Governors**

The full Council of Governors have had three presentations and discussions on the progress of the Annual Plan as part of minuted meetings with formal agenda's. During these meetings, the Governors had opportunity to question and feedback directly to the lead for the process. The Council of Governors have also had the same opportunities to understand, question and feedback on the process and aims of the organisations proposed Clinical Strategy, which is a significant element of the Annual Plan, at full Council of Governor meetings. The summary draft of the Annual Plan was presented and discussed at 14th May 2013 Council of Governors meeting with their support fed back to the May Board of Directors meeting for consideration.

2. Quality Strategy

2.1 Trust Quality Strategy

The Trust's vision for quality is outlined in detail within the Trust Quality Strategy 2012-2015. Our priorities for 2013/14 are focused on achieving our strategic quality ambition which is to:

'Deliver excellence in the quality of care and experience of every person, every time they access our services'.

In 2013/14 we will, through the second year of our Quality Strategy and our annual objectives, focus on five areas. These are to provide:

Priority 1	Person-centred care and improving patient experience;
Priority 2	Safe care by improving safety and reducing harm;
Priority 3	Effective care by improving clinical effectiveness and reliability of care;
Priority 4	An effective workplace culture that can sustain the above and enable quality improvement;
Priority 5	Deliver improvements incentivised through CQUIN's.

These priorities underpin the Trusts Quality Objectives.

2.2 Quality Objectives 2013/14

The Board is planning to agree a set of organisational values and clear day-to-day behaviours that will be built into appraisals, recruitment and drive every strategy, activity and target in order to launch a new culture in which the whole organisation pulls in the same direction to drive up quality of the patient experience, pathways and outcomes. Specifically, the annual quality objectives for 2013/14 are:

1) Implement the delivery plan in response to Francis Inquiry recommendations (2013). We have presented our plan to the Board and held open sessions for staff at each hospital to discuss the findings, raise concerns and suggest areas for improvement or change. This links directly to our plans to address the learning identified from the results of the Staff Survey in 2012 and the areas of action we have prioritised and to the feedback from our patients about their care and experience expressed in complaints and responses made using the NHS Choices and Patient Opinion websites.
2) Implement the second year of the Trust's Quality Strategy demonstrating improvements in patient safety, clinical outcomes, and patients' experience of person-centred care. There is a specific patient safety plan for 2013/14, which supplements the Quality Strategy.
3) To achieve a continuing improvement in the reduction HCAIs. The Trust has been set a challenging target of 29 avoidable Clostridium difficile (C.diff) infections and zero avoidable MRSA bacteraemias for 2013/14. We have been very effective in reducing these infections over the past five years however, achieving this target will be difficult. There is a detailed annual program of infection prevention and control in place with robust systems to assist in the early identification and decolonisation of colonised patients. There is a full investigation completed for all MRSA bacteraemias to ensure lessons are learned and improvements in practice made. Antimicrobial Pharmacists are in post across the main sites.

4) Deliver the CQUIN Programmes Commissioned by the Clinical Commissioning Groups demonstrating quality improvement and financial benefit.

5) Improve and managing 18 week pathways for elective care from referral to treatment and follow-up.

6) Work in partnership to ensure we deliver the four hour waiting time target in A&E.

2.3 **Risks to non-achievement of quality objectives and Compliance Framework 2013/14 Targets and Indicators**

The risks associated with the delivery of each quality objective are outlined within the Corporate Risk Register and any gaps in the control measures are monitored through the Board Assurance Framework. Quality risks are multi factorial and cross over several areas of the risk register and with the plan of action created in response to the two Francis Inquiry reports. The principle areas of risk are:

1) Patient safety, experience and clinical outcomes compromised through inefficient clinical pathways and patient flow resulting in unplanned use of extra beds with un-resourced staffing and patients outlying from their appropriate speciality, which may compromise patient safety and resulting delays. This is being managed by the Divisional leadership teams supported by improved access to relevant activity data via an electronic performance dashboard. We have invested in an electronic patient alert system, VitalPac, which monitors all inpatients and immediately alerts staff if a patient's condition is worsening. The system was implemented across the Trust during 2012/13. The annual review of the nursing workforce has been completed using agreed methodology and workforce tools. The Patient Safety Programme has been rolled out to the Divisions and the Trust is still working in partnership with Boston Consulting Group to assess the effectiveness of this programme.

2) Delivery of Year 2 implementation of the Quality Strategy
There are clearly defined quality targets and measures developed for 2013/14. There is a scheduled quarterly report to the Board, together with a performance dashboard for all the key areas.

3) Continuous Reduction in HCAI's Risk
The Department of Health C.diff target for Acute Trusts is calculated using a formula which takes account of bed numbers but also requires continuous improvement regardless of how low the rate of infection has been historically. Consequently, Trusts such as East Kent which already have C.diff infection rates in the best 25th percentile are required to improve further, while Trusts with higher rates of infection in many cases have been given targets which represent significantly higher rates of infection than the low rates of infection already achieved in East Kent. A target of 29 C.diff cases would represent a rate of 8.7/100,000 bed days. Only 15/163 Trusts achieved this rate in 2011/12 and of these 15, only 7 were multi-specialty Acute Trusts and all were relatively small. These Trusts represent outliers in terms of C.diff rates and whilst this may represent superior infection control performance, it could also be determined by a different casemix or differing C.diff testing protocols. When mono-specialist Trusts are removed from the equation the East Kent ranking is even more impressive with the East Kent rate of C.diff falling within the best 10th percentile (see Table 3 – Scatter Graph showing EKHUFT performance in 2012/13 benchmarked against other Trusts). It is unlikely that further major decreases in cases will be seen unless there is a change in the Trusts testing strategy (e.g. test fewer patients). The increasing pressure on activity within

the organisation also increases the likelihood of greater antibiotic use and more C.diff secondary infections.

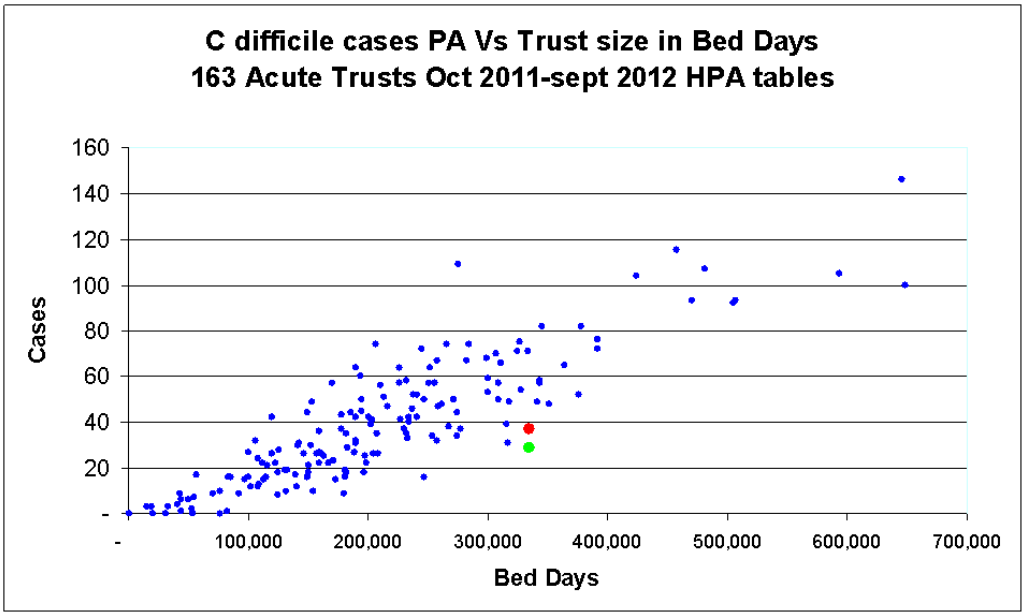

Table 3 – EKHUFT Benchmarked C.diff infection Rate Performance 2012/13

- **EKHUFT Actual cases October 2011 – Sept 2012**
- **EKHUFT DoH Target 2013/14**

For this reason it likely that case numbers for 2013/14 are likely to be in the range of 35 to 40. However the Infection Prevention Control Team have mounted an aggressive C.diff reduction campaign and it is possible that this will deliver some marginal improvements on the outcomes in 2012/13. Overall, the Trust perceives that pushing to achieve these very low rates may compromise our testing protocols. Lower rates should be our goal but our energy should be directed toward optimising our infection control procedures rather than over-analysing our performance. This will ensure that we continue to achieve low rates of infection and do not compromise the excellent test systems that are already in place. The Trust plans to deliver internal targets of:

- 6 MRSA bacteraemias (assigned to EKHUFT)
- 40 C.diff cases (post 72hrs) equal to 2012/13 performance

The Trust achieved 4 MRSA bacteraemias in 2012/13, however, the new Post Infection Review (PIR) process which requires acute trusts to be assigned cases where there are 'contaminants' (where they were [previously assigned to the non-acute sector), the Trust has increased the total by 2 to take account of this additional risk. Financially, the Trust has given consideration to the potential fines for non-compliance of HCAI targets within its forward plans.

4) Achieving the quality standards outlined in the 2013/14 CQUIN programme;
There are plans in place to achieve the CQUIN pre-qualification criteria by implementing Innovation, Health and Wealth priorities and we have agreed the national and local CQUIN areas for improvement with our commissioners.

5) Achieving 18 week waits for all pathways
There is a backlog of patients due to the high number of referrals outside the contracted level, specifically in the orthopaedic pathway. This is being managed within the Divisions led by Surgery.

6) Achieving Waiting times for A&E
The ability to meet the four hour standard is at risk due to increased demand for emergency services locally and nationally. Profiling of readmission activity for the frail elderly is in progress via a specific project work stream and the impact of NHS 111 on this objective is still being evaluated. Reablement schemes developed in conjunction with commissioners and community partners were not adopted in time in 2012/13. The ability to deliver the A&E standard is contingent upon these schemes being fully realised early in 2013/14. The main risks to achieving compliance therefore include:

- Insufficient external capacity to provide step down and active reablement to meet the demands required to reduce the level of reportable delayed transfers of care;
- Inability to secure additional agency medical staff prior to recruitment to substantive additional consultant and senior medical posts;
- Impact of 111 continues providing unpredictable patterns of attendances;
- Pace of change to establish Rapid Assessment and Treatment model to improve the speed of decision-making and referral to specialist opinion.

A recovery plan is in place and will be refined to ensure that performance improves and moves back into a compliant position. The Trusts improvement trajectory aims to be meet the standard in June 2013, however this is unlikely to result in achieving 95% for Q1. The Trust expects to be fully compliant from Q2 onwards.

2.4 **External Compliance**

Following the annual compliance visit schedule against Outcomes 2 and 4 of the Essential Standards for Quality and Safety, he Trust is still subject to two areas of moderate CQC non-compliance at the QEQM Hospital site. A review visit to the QEQM hospital has recently taken place; however the results of this reassessment are not yet available. The Trusts' views on the two areas under review are:

Outcome 2 – Consent to care and treatment. Specific plans are in place to ensure that all clinical staff are aware of their obligations under the Mental Capacity Act (MCA) 2005, that staff have access to specific training on the MCA, Deprivation of Liberty Safeguards and there is clear access to the relevant documentation at a single source for clinical staff. These actions have been supported by an increase in the level of staff specifically qualified in Adult Safeguarding.

Outcome 4 - Care and welfare of people who use services. The specific concern highlighted related to accurate documentation, update and care planning as a result of clinical risk assessments e.g. falls, nutrition, VTE and tissue viability. Several risk assessments are now available electronically and the remainder are planned to be available via VitalPac within this financial year. Accurate completion of risk assessment documentation now forms part of the clinical audit programme.

There are no areas of non-compliance at the Kent and Canterbury or the William Harvey Hospitals.

2.5 **Board Assurance on Quality**

The Quality Report and Quality Account for 2012/13 outlines where the Trust has met, and has not met the quality targets for the year. The Quality Report has been reviewed by the Board and the relevant sub-Board Committees to provide assurance of accuracy and balance. The Divisional leadership teams have been supported to develop their own Quality Governance Frameworks and evidence portfolios based on Monitor's Framework. These have been reviewed and will, in future, provide the support to the overarching evaluation of quality overseen by the Board.

3. Clinical Strategy

3.1 Strategic Vision of Clinical Services for East Kent Patients

Key elements of the Trust strategic vision for clinical services that it has built its Clinical Strategy on are:

- Six sites for outpatients services provision.
- Provision of Emergency services from three sites.
- Consideration of further centralisation of services to a single site in future with the potential transfer of Emergency Surgery onto one acute site.
- Day Hospitals/ Ambulatory Care Units (ACU's) in place to support Ambulatory Care activity, with an increase in Ambulatory Care and Short-Stay patient pathways.
- Step up and Step down beds supported by a Health and Social Care Village in collaboration with community and independent providers.
- Fully integrated healthcare model for the local people of East Kent.

3.2 In order to deliver this strategic vision for clinical services, address the issues that have been identified from the Francis review in addition to responding to the demand pressures the Trust is currently witnessing and the expected growth over the next three years, the Trust is well underway in working through the detail of three main clinical strategy reviews (Emergency Care, Outpatients and Planned Care). No individual investments have yet been agreed by the Trust Board for these reviews. However; it is certain that with the pressures experienced with the increasing demand on hospital facilities and staff to deliver safe effective care to patients that investment in the non-elective pathway will be required.

3.3 The Trust has assumed a worst case scenario and included a level of cost increase in its financial plans in 2014/15 and 2015/16. This will deliver the sustainable service required to manage the significant variations in service and the growing complexity of service provision. This investment, along with the development of Ambulatory Care and collaborative working with primary care and other secondary care providers, will manage demand more appropriately both keeping patients out of hospital and when they do have to be admitted ensuring their care is as safe and effective as possible.

3.4 Trust 2013/14 Clinical Strategy Workplan

The Trust initially had four clinical strategy work streams - Planned Care, Emergency Care, Trauma and Outpatients. With the Clinical strategy work stream reviews underway and full business cases being developed, the Emergency Care work stream now incorporates the Trauma service provision. The 2013/14 clinical strategy plan encompasses:

- Short Term – Increasing the number of Surgical Consultants to enable urgent reconfiguration of the Breast sub-specialty on-call rota as per recommendations from the Royal college of Surgeons (RCS).
- Short – Medium Term – Formal review through the Trust Investment Approval Process of the three Clinical Strategy Business Cases through to Board level by the end of 2013.
- Medium Term - Public consultation of the potential site options of the provision of Surgical Services. This was initially planned to be launched in the summer of 2013 however the process is currently paused whilst the Trust considers the overall clinical strategy priorities.

3.5 Clinical sustainability

As part of the Clinical Strategy Review and because of clinical governance concerns, an invited review was requested from the Royal College of Surgeons (RCS). Two visits were carried out over 4 days in October and November 2012 and the initial report was received in January 2013. A number of issues of factual accuracy and presentation were raised by the EKHUFT in February 2013 and the RCS agreed a number of amendments in March 2013.

Clinical governance concerns related to variability in service provision between WHH and QEQM and some aspects of leadership and collaboration were raised. Specific questions were posed about upper GIT surgery; bariatric surgery; complex incisional hernia surgery and cancer pathways. Following constructive comments an Action Plan has been produced by the surgeons and the RCS may revisit to monitor progress. EKHUFT can confirm that overall outcome data for general surgery is better than peers with a relative mortality risk of 90 recorded by Dr Foster.

The RCS endorses the Trust position that centralization of emergency high and medium risk surgery on a single hub will be necessary in the future. They highlight the need for breast surgeons to demit from general emergency surgery as soon as possible and for interventional radiology services to be available 24/7. The inter-dependence of gynaecology, children and accident and emergency services still requires review. Their recommendations will be considered within the engagement process of the Clinical Strategy.

4. Workforce Strategy

4.1 Workforce Plan Overview

Despite a reduction in headcount last year, accounted for in the main by the TUPE of staff to other providers, the underlying trend is an increase of staff in line with increased activity. This year as a result of activity and income assumptions, the workforce will remain stable therefore we do not predict any material changes to the WTE in year. The turnover rate means that approximately 500 WTE staff leave the Trust per annum which allows EKHUFT to flex the workforce in year, should the situation change unexpectedly. Overall there is currently a good mix of permanent, bank and agency staff. However there is a recognised over reliance on agency middle grade doctors in A&E and Paediatrics that will, in time, be helped by the development of the Clinical Strategy. The Trust has, through the tightening of Agency Frameworks, reduced the unit cost of agency doctors. However the overall usage has increased compared to plan. The FT workforce plan has been developed using the templates from the DH Workforce Assurance tool and this information, once approved by the Board of Directors, will be input to the benchmarking tool for review.

4.2 Clinical Strategy Impact

The Clinical Strategy is currently being discussed with key internal stakeholders. The strategy considers planned care, outpatients care, emergency care and trauma. As part of this development independent advice was sought from the Royal College of Surgeons around surgical options and their appropriate clinical adjacencies. It also incorporates the recent analysis of our services against the sustainability findings of Mid Staffordshire NHS Foundation Trust. Its purpose is to deliver a sustainable consultant delivered service through reconfiguration and changes to working practises. Ultimately consultants, pharmacists and therapists will be required to work a more 24/7 model, as their radiography, nursing, junior doctors and pathology colleagues already do.

4.3 Nursing Skill Mix Review

A nursing skill mix review has recently been undertaken for Ward based staff using the AUKUH (Association of UK University Hospitals) and Hurst models, this will report to the Board of Directors in May 2013. The review has considered the optimisation of effective rostering through the use of the MAPs system, triangulation of the quality indicators with the NHS safety thermometer, and input from 1-2-1's with all ward managers. The outcome of this review has informed the nursing workforce plan and will be implemented, subject to approval of relevant business cases, in year. Workforce pressures in the delivery of emergency care are reflect national trends and are part of the consideration of the Clinical Strategy and as well as an in year business case.

4.4 Recruitment Plan

Recruitment hotspots include experienced band 5/6 nurses in emergency care (A&E and CDU) which will be addressed by an overseas recruitment plan in year for experienced nurses who do not require preceptorship. Sonographers, are small in numbers, but are also in short supply and this will be addressed through improving the robustness of our existing internal training programmes and overseas recruitment. Due to a 25% increase in activity EKHUFT has had to increase the supply of Chemotherapy nurses, this has been achieved through external recruitment and an internal training programme. Currently the fill rate for bank nursing provided by NHSP has fallen and EKHUFT is working with them to implement an in-year programme to recruit 30 overseas registered nurses to support this shortfall.

4.5 **Administration and Clerical Staff Review**

This year the outcome of the Admin and Clerical (A&C) job roles review will be implemented which incorporated the use of new technology and team-working to either reduce the numbers of staff employed or reduce the Agenda for Change Bands on which they are paid. The outcome is a significant change in skill mix. Junior doctor's bandings are also continually reviewed, especially within the Surgical Division, to ensure value for money.

4.6 **Sickness/ Absence Reduction Plan**

Activity to reduce sickness absence to the target of 3% by 2014, from the current target of 3.3% is on-going though progress is variable across the Trust. This year EKHUFT is taking part in an NHS Employers support project as part of the DH QIPP programme to aid progress in achieving this target. This will be aligned to an internal staff health and well-being project.

4.7 **Staff Engagement**

As part of the Quality Strategy, in particular Goals 1 and 4, and the achievement of annual objective AO7, a comprehensive staff engagement programme was developed in year. In financial year 13/14 the further roll out of the Aston Team Working Model will support the achievement of these objectives alongside the 'We Care' Programme which afforded staff and patients the opportunity to identify key behaviours and develop behaviour standards. The outputs of this combined, with the Francis report listening events, will support on-going engagement. A clinical leadership development programme for doctors, nurses and allied health professionals based on the, internally developed, shared purpose framework competencies is in place for delivery in year. A partnership approach facilitated by ACAS between the organisation and Trade Union representatives in 2012/13 will help to improve formal engagement. A revised talent management approach has been developed with Canterbury Christ Church University and will be implemented in 2013/14 to support a more robust succession plan for key posts within the Trust, particularly at divisional director level. A clinical leadership development programme for doctors, nurses and allied health professionals based on the shared purpose framework competencies is also in place for delivery in year along with a plan for the revalidation of doctors that continues into future years.

5. Productivity and Efficiency Plans

5.1 Planned Productivity and Efficiency Gains

The 2013/14 Efficiency Programme is a reflection of the mid stage position the Trust has reached in its 3 year rolling programme, initiated in 2012/13. The Trust has approached this task using two complementary themes:

- Strategic – redesigning the business and clinical model to adopt new models of care for the system as a whole along with improving the underlying economics, and;
- Operational - significantly improving the productivity of current business and clinical models.

As such the plan incorporates a range of productivity and efficiency gains across the above areas at the same time as recognising the interdependency of plans, particularly where one initiative will influence another, for example market expansion plans require additional beds at same time as patient pathway developments (length of stay reductions) indicate bed reductions. These factors are therefore key indicators within the Trusts balanced scorecard governance system, reflecting the interrelationship between productivity, efficiency, quality and safety within our overall plan.

In overview terms, Table 4 outlines the financial values that are included as efficiency gains within the 2013/14 to 2015/16 plan;

Savings Subjective Headings	2013/14 £m	2014/15 £m	2015/16 £m
Income SLA	4.4	2.5	3.5
Income Other	2.2	1.0	1.5
Workforce	13.0	12.3	10.9
Non pay clinical	5.8	4.3	2.6
Non pay non clinical	2.4	4.1	3.9
Miscellaneous	0.8	0.5	0.3
Drugs	1.4	1.3	1.3
Totals	**30.0**	**26.0**	**24.0**

Table 4 – Trust High Level 2013/14 Efficiency Programme

5.2 Three Year CIP Programme

The East Kent Hospitals University NHS Foundation Trust has a proven track record in the successful planning and delivery of Efficiency Programmes over recent years, for example 2010/11, plan £20m actual £21m and 2011/12 plan £20m actual £24.7m and 2012/13 plan £30m actual £30.6m. The main factors of success have been the combined approach of Corporate and Divisional schemes with an evolving understanding and ownership of the Financial Strategy across the organisation. The Trust recognised in the 3 year programme that a strategic approach to efficiency planning is imperative for future success. Cost savings deliverable from traditional sources and approaches as outlined above, are now considered unlikely to be achieved without major transformational service redesign from 2014/15 onwards. The approach and support requirements to develop this strategic programme are currently being considered in association with the Executive and Divisional Directors. An outline set of corporate and transformational programmes, see below, is being developed and will be assessed for progression as part of the updated Financial Strategy proposals due in June 2013.

- Community service integration (inc integrated urgent care service model)

- Back office programme
- Clinical strategy (inc clinical service reviews)
- Marketing (NHS & Private patients)
- Kent Pathology Network
- Workforce efficiency programme
- Supplies & Procurement programme
- Medicines management
- Theatre efficiency programme
- Outpatient service improvement programme
- Unprofitable services (SLR review)
- Estates and space utilisation

Management of the development, monitoring and reporting of the Efficiency Programme is the responsibility of the Programme Office within the Finance & Performance Management Directorate. The responsibility for the delivery of efficiency plans rests with the Corporate Programme Leads (with Exec sponsorship) and the Divisional managers for local schemes.

5.3 **CIP Governance**

All plans are RAG rated to reflect the assurance status for delivery;

- Red – project opportunity identified but yet to be scoped (low confidence about delivery)
- Amber – project scoped or values confirmed with key actions pending, e.g. investment decision
- Green – project developed and ready for implementation (high level of confidence of delivery)

All plans are risk assessed in their development as part of the RAG rating and the monitoring of the overall Efficiency Programme is part of the Trusts performance management framework, through the Balanced Scorecard. The ongoing impact of CIPs on services is measured primarily through the balanced scorecard assurance system. Two indicators are monitored specifically relating to the Efficiency Programme, namely;

- Status of Efficiency programme plans (plan at Green as % of target)
- Delivery of Efficiency Programme (actual as % of target)

These indicators apply both Trustwide and at individual Division levels, alongside 70 other performance metrics, including compliance with access, quality, patient safety, effectiveness and patient experience targets.

The CIP position is reported monthly to the Executive team, Finance & Investment Committee (FIC) and Trust Board meetings. The monthly position and performance metrics within the balanced scorecard are subject to scrutiny at monthly Executive Performance Reviews held with each Division. The Strategic plan is also regularly reviewed at Executive and FIC meetings to reflect current and future financial environments, lessons learnt from past year planning and delivery of savings and consideration to the key areas for service transformation and efficiency gains.

5.4 **CIP Profile**

The Trust recognises that major transformational service changes will be required to ensure delivery of future financial efficiencies. The Trust has a major Clinical Strategy programme, initiated over recent years, that aims to consolidate clinical services across the Trust in the safest and most efficient way over the next few years, This work will contribute, in time, to the Financial strategy alongside other major initiatives such as the Pathology Network programme (alliance between Maidstone & Tunbridge Wells NHS Trust and East Kent).

Background analysis of service activity and financial information, through service line reporting and profitability reviews is currently being undertaken to inform the decision making process for future service provision and redesign. Detailed assessments of key service indicators at Divisional level is also planned for coming months to coincide with the revised Financial strategy (June/July 2013) and subsequent agreement to the approach to be taken for the 2014/15 Efficiency programme and beyond.

5.5 **CIP Enablers**

The Financial strategy is a key subject in the many presentations given by Finance staff to the organisation, including new Consultant Development programme, Operational Leadership sessions, Chief Executive forums as well as at Divisional Management Board meetings. With over half of the savings plans being initiated at Divisional level, the Divisional teams take a multidisciplinary approach to identifying and actioning agreed plans. Clinical leadership has been to the fore in an number of areas, particularly in the market expansion programme with 'invest to save' opportunities being put forward and the plans, once supported, successfully implemented by clinical staff. Sign off of Divisional plans is by the Divisional Management Boards.

The Programme Office (PMO) was developed in 2011 and is the principal resource for development and monitoring delivery of the Efficiency Programme. Additional expertise or advice has been sought at times to provide audit and assurance to practices and processes and also for an independent view on efficiency opportunities. The PMO will shortly implement a new Programme/Project Management IT system to support the recording, reporting and promotion of the Efficiency programme and provide a structured platform for the future transformation and service redesign programmes and projects required in the coming years.

5.6 **Quality Impact of CIP's**

The governance process behind the Efficiency programme provides assurance to the planning, delivery and impact of the savings plans at many levels of the organisation. This process has recently been audited by RSM Tenon the Trusts Internal Auditors, who concluded that "Taking account of the issues identified, the Board can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective".

Within the planning process for individual efficiency schemes, risks are assessed not only for financial delivery but also impact on other key measures, quality and patient safety, workforce and patient experience. Divisional plans are signed off by Divisional Management Boards and the Corporate programmes are led by an Executive Director. At regular intervals through each year, plans are discussed at Executive and Finance & Investment Committees and assurance is sought from the Chief Nurse, Director of Quality & Operations and Medical Director that plans will not adversely affect quality and safety of services. The ongoing impact of CIP's on services is measured primarily through the balanced scorecard assurance system. Two indicators are monitored specifically relating to the Efficiency Programme, namely;

- Status of Efficiency programme plans (plan at Green as % of target)
- Delivery of Efficiency Programme (actual as % of target)

These indicators apply both Trustwide and at individual Division levels, alongside 70 other performance metrics, including compliance with access, quality, patient safety, effectiveness and patient experience targets.

6. Financial Strategy 2013-2016

6.1 The Trust ended 2012/13 with a surplus of £4m after the impact of the impairments amounting to £4.8m including those associated with the Dover Hospital development. This surplus and a cash balance of £60.1m helped the Trust maintain a financial risk rating of 4. The Trust's reference cost indicator stands at 100.08 (RCI).

6.2 Through a combination of tariff reforms and potentially increasingly effective measures to reduce the demand for hospital based services by CCGs it is unlikely that the Trust will see significant activity and income growth in the future other than by increasing "our share" of Kent Commissioners spending. The Trust's financial strategy is to ensure that there are sufficient funds not only to maintain the sustainability of services to its patients but also to provide funds to continually improve the Trusts services both in its quality and accessibility. This will help ensure that the Trust's market position is maintained and that services are marketable to new geographic areas and that opportunity around developing new and sustainable services. It is within this context therefore that the Trust intends to achieve a surplus. The size of the surplus needs to be sufficient enough to:

- create the necessary resilience or contingency to withstand fluctuations in income
- support the Trusts Clinical Strategy
- to allow for investment to improve the quality of services

	£m 2012/13	£m 2013/14	£m 2014/15	£m 2015/16
NHS Clinical Income	460.1	458.1	453.9	450.9
Other Clinical Income	3.7	5.6	6.0	7.0
Other Income	37.6	36.9	36.9	37.0
Total Income	**501.4**	**500.6**	**496.9**	**494.9**
Pay Costs	(293.8)	(292.8)	(287.0)	(280.7)
Drugs	(41.8)	(43.7)	(45.0)	(46.6)
Other Costs	(132.6)	(132.7)	(132.0)	(133.7)
Total Operating costs	**(468.2)**	**(469.1)**	**(464.1)**	**(461.1)**
EBITDA	**33.2**	**31.5**	**32.8**	**33.8**
Depreciation	(16.2)	(16.9)	(17.7)	(19.0)
Impairments	(4.8)	(0.5)	(3.4)	(0.5)
PDC	(8.2)	(8.6)	(9.0)	(9.3)
Other below EBITDA costs	0.0	(0.1)	(0.1)	(0.1)
Retained income	**4.0**	**5.4**	**2.6**	**4.9**

Table 5 – Trust Summarised I&E Statement

6.3 To this end, the financial plan for the Trust includes prudent contingencies to mitigate emergent issues such as the potential impact of recommendations from the Francis Report as well as other service improvement plans for 2013/14. The potential funding of prospective service developments in 2014/15 and 2015/16 have also been built into the Trust forward plans.

6.4 As part of the 2013/14 plan, the Trust initially set itself a 'worst case' efficiency requirement of £30m. Subsequent negotiations with Commissioners have demonstrated the validity of this figure. For the forward two years, Cost Improvement Plan (CIP) targets of £26m (5.2%) in 2014/15 and £24m (4.8%) in 2015/16 have been set on the premise that:

- The tariff efficiency signals indicate a built in tariff efficiency of 4% per annum.
- Growth will be marginally negative (-0.2%) based on the underlying growth (0.8% pa) less 1% per annum for commissioning intentions.
- Funding for potential investments to support the Trust's Clinical Strategy in 2014/15 and increases to the contingency in both 2014/15 and 2015/16 for any recurrent cost increases that may result from further service reviews, contract changes or decisions over investments to improve service quality. It is difficult to predict the impact of service change for 2014/15 and beyond so the Trust has built in further contingencies against the potential risk of either increased costs or fluctuating income streams.
- The Trust is required to maintain enough cash resources to allow for the maintenance and development of the estate and equipment to support the effective delivery of clinical and non-clinical services. The Trust plans to maintain its strong cash position throughout the plan and this supports capital investment of £30.8m in 2013/14, £32.5m in 2014/15 and £29.9m in 2015/16 (excludes assets purchased with charitable funds).
- Maintain a financial risk rating of at least 3.

6.5 The Trust is developing its CIP programme with a combination of service transformations both system wide and at a Trust level and smaller schemes driven by a push for service efficiencies. To support this process the Trust has developed a sophisticated SLM system which allows service leads to review profitability and efficiency at consultant level by the delivery at HRG level.

6.6 The Divisional structure the Trust has adopted allows for a system of control to be put in place that is managed through a monthly/quarterly review system that rewards excellence with managerial freedoms and financial rewards for service development. This system has allowed a more bottom up approach for "next year" service planning with the Trust executive leading the development of longer term strategies with the support of divisions. This is part of the Trust's drive to encourage cultural change and financial leadership from clinical professionals.

6.7 The Trust will continue to cultivate close links with commissioners in order to develop services delivered by the Trust and improve the economic stability of both the Trust and local commissioner organisations. An example of this is the role the Trust is leading on the development of a new Urgent Care service, collaborating with local CCG's and other secondary care providers. The continued financial strength of the organisation is key if the Trust is to continue with this central role in the local health economy. The Trust is keen to work with CCGs to moderate growth as peaks in growth do cause financial stress to the Trust as costs structures can change if activity increases significantly over short periods.

6.8 A number of risks have been examined in drawing up the plans for the Trust. The potential risks that score highly for consequence are non-delivery of CIP and the impact of commissioner's actions on Trust income. Mitigation of these risks will be through close scrutiny of performance and performance trends with timely action under the scrutiny of the Trust' Finance Committee and holding significant financial contingencies.

6.9 The Trust will seek to maximise the benefit from the ownership of the Spencer Wing private hospital at Margate. The Spencer Wing is located on the QEQM Hospital site and is the single largest provider of independent sector capacity to the Trust. Its acquisition also aids the Trust in developing services to the private sector.

6.10 The sensitivity of any potential downside has been examined in the financial appendix which accompanies this strategy. A sound financial footing has been the base for the Trusts overall performance achievements in the past and will continue to be essential for the Trust in future years.